VDSS MODEL FORM - ALF

RECORD OF ON-SITE HEALTH CARE OVERSIGHT FOR ASSISTED LIVING CARE RESIDENTS

QUARTER FROM: _____
Month/Year

TO: _____
Month/Year

NAME OF ASSISTED LIVING FACILITY: _____

A licensed health care professional's signature attests to the fact that he/she completed the specified responsibility/function on the date so noted. At least quarterly on-site visits are required except that for auxiliary grant recipients who are intensive assisted living residents, on-site visits must be at least monthly. A separate form should be utilized for each quarter (3 months).

RESPONSIBILITIES/FUNCTIONS	DATE(S)	SIGNATURE(S) OF LICENSED HEALTH CARE PROFESSIONAL(S)	COMMENTS, IF NEEDED
1. Recommending in writing changes to resident individualized service plans whenever plans do not appropriately address current health care needs.	_____ _____ _____	_____ _____ _____	
2. Monitoring direct care staff performance of health related activities.	_____ _____ _____	_____ _____ _____	
3. Advising administrator of need for staff training or other actions when appropriate to eliminate problems in competency level.	_____ _____ _____	_____ _____ _____	
4. Providing consultation and technical assistance to staff as needed.	_____ _____ _____	_____ _____ _____	
5. Directly observing every resident with care needs equivalent to intensive assisted living criteria and recommending in writing any needed changes in care provided or in resident individualized service plan.	_____ _____ _____	_____ _____ _____	
6. Reviewing documentation of health care services, including medication and treatment records to assess that services are in accord with physicians' orders, and informing administrator of any problems.	_____ _____ _____	_____ _____ _____	
7. Reviewing condition and records of residents for whom restraints are used to assess appropriateness of restraint and progress toward its reduction or elimination, and advising administrator of any concerns.	_____ _____ _____	_____ _____ _____	